

CDC Public Health Preparedness Conference 2005
Roundtable Discussions
Crowne Plaza Ravinia, Ravinia Ballroom

Thursday, February 24, 2005 12:15 p.m. – 1:15 p.m.

This summary resulted from a one-hour Roundtable Session that occurred at lunchtime during the CDC Public Health Conference 2005 on Thursday, February 24, 2005. Approximately 350 conference attendees participated in the concurrent roundtable discussions that addressed 20 public health topics related to bioterrorism preparedness and response. (see page 2)

A facilitator and a notetaker were assigned for each roundtable topic. Participants selected and attended the topic of his/her choice. Participants communicated the desire to have notes from the Roundtable Session posted on the conference website in order to share their thoughts and ideas with others who participated in the various roundtable discussions. The following “notes” reflects a variety of formats, writing styles, and content summaries based on the diversity of the facilitators, note takers, and participants for each topic. The reader is reminded that due to the limited time dedicated to this special conference session that scribes were requested to take “notes” to capture the highlights of the discussions, whether in phrases or complete sentences.

Topics

Please click on the specific topic to view the roundtable discussion notes:

1. [*American Red Cross*, Facilitator: Darlene Washington](#)
2. [*BDS*, Facilitator: Dan Sosin](#)
3. [*Biological Laboratory*, Facilitator: Emory Meeks](#)
4. [*Border Health*, Facilitator: Shah Roohi](#)
5. [*Chemical Laboratory*, Facilitator: Andrea Lipman](#)
6. [*Chempack*, Facilitator: John Michaels](#)
7. [*CRI*, Facilitator: Tim Quinn](#)
8. [*Crisis and Emergency Risk Communication*, Facilitator: Barbara Reynolds](#)
9. [*Evaluation/Performance Measurement*, Facilitator: Chris Bradshaw](#)
10. [*Informatics*, Facilitator: Laura Conn](#)
11. [*Pandemic Flu Planning*, Facilitator: Pascale Wortley](#)
12. [*Partners \(NACCHO, ASTHO, APHL\)*, Facilitators: Claudine McCarthy and Stephen Curren](#)
13. [*Psychosocial Issues*, Facilitator: Dori Reissman](#)
14. [*Smallpox Vaccination*, Facilitator: Joanne Cono](#)
15. [*Special Populations/Children and School Health*, Facilitators: Chris Kochtitzky and David Delozier](#)
16. [*Special Populations/Adult and Community Health*, Facilitator: Maggie Moore](#)
17. [*Strategic National Stockpile \(SNS\)*, Facilitator: Pat Nonnenmacker](#)
18. [*Surge Capacity*, Facilitator: Gary Rhyne](#)
19. [*Syndromic Surveillance Methodologies*, Facilitator: Tracee Treadwell](#)
20. [*Training and Education*, Facilitator: Lynn Steele](#)

American Red Cross

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No notes available at this time.

BDS

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The Roundtable discussion brought together a wide range of BDS issues from public health leaders at all stages of developing response plans. Since the publication of the CDC's MMWR on autonomous detection systems, additional questions have surfaced and state and local implementation planning with USPS has resulted in varying guidelines and agreements for response. Many of the issues have been raised previously and are currently being worked on, but this discussion highlighted the need to more effectively communicate guidance and share experiences.

Program Challenges

- Need for national guidance for issues not identified in the MMWR where variation has made response planning challenging
 - Regional differences in supplies of antibiotics
 - Differences in expectations for receiving lab confirmation
 - Varying approaches to decontamination and evacuation
 - Different approaches to managing risk, cost/benefits
- Need for consistent communication between USPS and public health agencies
 - Collaboration with local USPS stations has been inconsistent
 - USPS has activated BDS in some locations without prior notification of public health
 - Public health having to fight for a place in BDS implementation planning
 - Mixed message regarding national versus local planning authority
- Need for clear statement of roles and expectations for USPS and state/local health agencies
 - Public health's expected role vs. its capacity to fulfill that role (long term care of exposed workers; administration of vaccine and antibiotics)
 - How will planning and response be financed?
 - Who will be traced for disease and adverse events [spell this out] and who will conduct the tracking?
 - Public health agencies' suitability for management and distribution of prophylaxis
 - Long term care a corporate responsibility or a public health responsibility?

- Classification of USPS as a private company or a federal agency
- Would exposure be considered occupational?
- Timing of post-exposure prophylaxis (PEP) – Should not be done until there is LRN verification, but some areas have too long of a time delay in awaiting results.
- Risk management issues related to non-USPS employees & the public
 - Plans to environmentally assess public areas after a BDS alert
 - Potentially exposed vendors or truck drivers may be contractors, not employees
 - Expectation that contaminated mail will still be in the postal facility or on trucks at the time of a BDS alert and will be able to be called back
- Issues requiring additional guidance
 - Continued work on advance risk communications plans and the development of educational materials for postal employees, the health care community and the general public.
 - Defining the federal role in a bioterrorism or bio-crime involving the postal service
 - Multiple signals
 - Events would be considered related
 - Escalating the response plan (ex. Distributing PEP before LRN verification)
 - Upstream investigation needs and coordination
 - Procedures for resuming mail service under the threat of more letters in the system
 - Interagency coordination to meet environmental sampling and testing needs (including the timeliness requirements)
 - Protocols for personal bio-decontamination that balance needs for public protection and individual liberties
 - Requirements to managing bio-decontamination wastewater for suspected anthrax
 - Including health care facilities in response plans
 - Issues related to PEP
 - Optimizing compliance with PEP after a verified alarm
 - Managing the interval between alarm and the decision to distribute PEP
 - Need to assess what is going on in different states and to share that information

State/grantee requests of CDC

- Technical advice and more coordination at the national level
- Clarification of responsibilities between USPS and public health
- Communication with state and local health agencies on implementation FAQs
 - CDC has FAQs available for issues that have been resolved.

- Secure forum to share guidance and experiences, such as a website or listserv. Such a forum would allow states to share information about their BDS implementation plans, best practices and the status of their efforts.
- Because BDS is currently being rolled out in the states, the discussion focused more on identifying challenges and sharing information related to implementation than on developing innovative solutions. As BDS is installed in more states, there will be a greater opportunity to discuss innovative approaches to the issues previously identified.
- Participation in April's stakeholders meeting with USPS and other agencies

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Biological Laboratory

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No notes available at this time.

Border Health

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State Updates:

- Michigan
 - Participated in a Cross-Jurisdictional Collaborative (Bi-National) Steering Committee conducted a Public Health survey.
 - Ontario-Michigan Conference held in September 2004 to address the preliminary assessment of survey and develop 5 subcommittee workgroups—lab, communication, legal, emergency response and direct care (Co-lead by representatives from MI, NY, MN, WI and Ontario).
 - 4000 health care workers cross into Michigan from Ontario for work making border crossing (and a potential border closure) a vital issue.
 - Hosting Annual Border conference September 8–9, 2005
 - Compatible RODS-based syndromic surveillance system
- Washington State
 - Hosted a regional conference for 6 states and 3 provinces in August 2004.
 - Planning for Pandemic Flu workshop to be held April 18–20 in Vancouver, British Columbia, and will address isolation/quarantine, resources and credentialing issues

- Development of a Cross-jurisdictional website (Washington Secures) for emergency response which is owned by WA and allows for document sharing
- Has been working on mutual aid agreements with neighboring provinces.
- Vermont
 - Collaboration preceded EWIDS.
 - Belongs to a regional consortium along with NY, ME, VT, NH in working with Quebec.
 - Local level interactions are going well, but province level interactions have been more challenging to organize.
 - April 2005 Bangor, ME will host a surveillance Epi meeting with the Maritime Provinces, Quebec (ministry level) and NH, VT and NY
 - Planning conference calls and meetings involving hospitals regarding Pandemic Flu efforts for a large fall conference
 - Building on close ties with Montreal
 - ID specialists from adjacent province will be coming to Burlington to conduct a Clostridium difficile (C. diff) presentation and discussion.
- Arizona
 - Historical good relationship with the State of Sonora, Mexico and border health offices in Tucson, AZ
 - Four border counties collaborate on emergency response, exercises, and the sharing of patient transfers, resources through local level MOA, mutual aid agreements and cross-jurisdictional response plans
 - Cross-jurisdictional border training for lab directors and epidemiology staff leads to sharing of system plans, other infrastructure equipment and the movement of supplies/resources during a mass casualty event
 - Use of EWIDS funding modified/enhanced electronic disease surveillance system for all hospitals and labs where all border communities can access data

Other issues discussed:

- Jurisdiction international event from the law enforcement perspective and the establishment of the EOC
- Political-economic impact
- Horizontal communication
- Laboratory LRN expansion—data sharing agreement
- Legal—need authority for collaboration
- In surveillance, there is a lack of standard definitions
- Exchange of 24/7 contact lists
- Provincial governments (lab and public health veterinarians exchanging information/protocols on outbreaks and disease clusters
- CSTE and APHL global health workgroups

- Canadian Provisional to U.S. local variability
- Standard surveillance and lab competency definitions
- EMAC and MOA facilitation by CDC for templates to be used in cross-jurisdictional collaboration

Recommendations:

- Quarterly calls with HHS and CDC, north border states with a purpose of gaining more support for cross-jurisdictional issues for efficiency from the CDC Public Health law Program in the form of templates for the entire northern US-Canadian border, providing updates, sharing continues collaboration success stories.
- Encourage interstate collaboration this program year.
- Promote border health listserv.

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CHEMICAL LABORATORY

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Issues Raised for Discussion:

- Guidance
- Funding Issues
- Performance Goals
- Budget
- Alternative Funding Methods
- Food & Environmental Testing
- Functioning with Reduced Staff

Program Challenges:

- Programs are currently hesitant to hire staff due to concerns over instability in the future funding stream (potential inability to sustain programs).
- Although CDC is providing technical assistance for the analysis of biological specimens, there is no similar guidance generated by EPA for the analysis of environmental specimens. FDA is also lagging behind.
 - Can CDC work with EPA to move their program forward?
 - Andrea indicated that it is not EPA's mission to perform chemical terrorism testing since they are a regulatory agency
- Travel to CDC trainings and meetings is becoming increasingly difficult in some states. Will CDC renew the direct assistance option for travel for the upcoming guidance?
- How do programs maintain their chemists' interest in the program?
 - As states take on more methods, they will do more proficiency testing, additionally, they can offer to collaborate with our program on methods development

- Work on those pilot studies that you proposed with your bio-monitoring planning grant partners

CDC Issues:

- Some indicated that they would like more specific guidance on the types of specimens (other than biological) that CDC will allow to be analyzed on the instrumentation purchased for Focus Area D – We left the guidance intentionally broad so that we did not have to answer numerous “what about this type of specimen or this matrix” type questions.
- What will the new guidance look like? – Programmatic activities will remain the same.
- How will CDC select the next Level-three laboratories? – Performance as a Level-two laboratory, successful proficiency testing, and the location in the country (ensure geographic diversity)
- Can Level-two states obtain methods training from Level-three laboratories in lieu of waiting for CDC training times to open up? – No. Coming to CDC for technology transfer is an important part of the program.
- What equipment is required for Level-two laboratories desiring to move to Level-three status?
 - LC/MS/MS
 - HPLC front-end for ICP-MS
 - Note additional personnel needs
 - Note security requirements

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CHEMPACK PROJECT

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Program Challenges:

- Following participant introductions, Mr. David Adcock, the CHEMPACK National Coordinator, opened discussing with the challenges of the CHEMPACK Project. He shared with the group the mission of the CHEMPACK Project, the existing requirements, current progress and expected fielding completion times. Additionally, he discussed the current status of fielding, stated Project expectations, and encouraging all to share their concerns and challenges regarding participation in and preparations for the Project.
- Over the past year, the CHEMPACK Project has faced numerous challenges and manages to provide solutions that made the program efficient and simple to execute. First, the initial goal was to have all 62 Bio-Terrorism Project Areas (BTPA) completely fielded by December 2005. This goal has been modified to accommodate product manufacturing challenges of pharmaceuticals and hardware. All BTPAs are aggressively working to make receiving CHEMPACK a reality in their Cities and States. These efforts are most

certainly appreciated. During the course of fielding, the following observations can enhance measures to secure CHEMPACKs in the Cities and States in a timely manner:

- Develop a well written CHEMPACK plan that integrates CHEMPACK into the current or existing ESF-8 or All Hazards Plan.
 - Determine, within the CHEMAPCK BTPA allocation, the number and the type (EMS or Hospital) of CHEMPACKs to be placed within the BTPA.
 - Select a single Point of Contact (POC) and an alternate to work with the CHEMPACK Project Regional Coordinator at the CDC.
 - Select cache locations to best suited for covering key high risk populations and areas.
- Once these four fundamental steps have been completed the BTPA is ready to schedule the CHEMPACK surveys. Once the cache location surveys have been performed and cache locations build-out to receive the containers, usually within 30 days the CHEMPACK fielding can be scheduled. The CDC will provide the technical assistance needed to deliver, install and test the CHEMPACKs, and conduct follow on quality control sustainment operations. The project is designed to provide seamless integration into the Site with minimum sustainment costs.
 - During the course of fielding more than 470 CHEMPACK containers we have learned that when the required analog phone lines (POTS) Plain Old Telephone Service that significant delays were encountered or the CHEMPACK Project was unable to install the CHEMPACK containers into the designated cache locations. On average, all other requirements were either satisfied or corrected on the spot during initial delivery. The average time to conduct a cache location fielding is 60 to 90 minutes.

CHEMPACK Project Issues:

- The U.S. Virgin Islands addressed a unique concern that relates to their geography; because the Islands are separated by water it is very difficult to transport CHEMPACK pharmaceuticals to locations in a time effective manner. One conference attendee suggested that the containers be placed in two locations on different Islands. This would help minimize the risk exposure and enhance the time required to deliver these products to the site of an incident.
- HRSA and BTCA funds were available to defray the initial build-out cost involved with fielding the CHEMPACK containers. Participants were encouraged to discuss build-out funding issues with their State's HRSA and CDC BT Project Officer. Practice containers were being built and would be available within the next few weeks. The CHEMPACK practice containers will be delivered in three phases: first to receive practice containers will be those BTCAs who have been fielded; second will be scheduled to be fielded; and third, those BTCAs who directly request the practice containers before they are scheduled for state or city wide fielding. Participants were encouraged to develop

CHEMPACK practice container training and exercise plans and exercise their personnel in the use and distribution of CHEMPACKs using the practice containers.

Innovative Ideas:

The State of Alabama offered to assist any BTCA that wanted to take advantage of the lessons they learned during the planning, staging, and deployment of their CHEMPACK containers.

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CRI

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No notes available at this time.

CRISIS AND EMERGENCY RISK COMMUNICATION

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Program Challenges:

Question: How to tackle getting resource materials translated into “plain English” – Most of the materials are written on much too high a level.

Response: This information will be passed on.

NPHIC Issues:

Comment: Request to NPHIC for advice not responsive – Wyoming sent emails to NPHIC for advice for media training He had hoped to receive recommendations from NPHIC on the topic, instead he has been receiving emails directly from vendors.

Response: Emails from NPHIC are not available to CDC and recommended any requests for information and advice be sent directly to CDC’s subject matter expert for communication.

NPHIC Comments and Issues

- Question: Why is NPHIC being used?
Response: The decision to use NPHIC to reach Focus Area F Leads was made by CDC senior management.
- Comments
 - “NPHIC only allows ‘voting members’ to really voice their opinions and NPHIC only approves Chief Public Information Officers for the state to be voting members.”
 - “NPHIC is a great organization but their mission is more overarching than our Bioterrorism Cooperative Agreement (BTCA).”

- “Focus Area F staff usually are not permitted to attend the media conference unless they are the State PIO.”
- “Any leadership and other materials are only sent to the PIO and may never get to the Focus Area F staff.”

Response: CDC representatives continues to speak with NPHIC Board about various issues. CDC began building list serve but it was shut down because of difficulties maintaining it with no resources (no money, staff, etc).

- Comments:
 - CDC needs to understand that although NPHIC is convenient, they do not always serve the purpose for Focus Area F staff. In some states (primarily those where the PIO is also the Focus Area F staff), it works well but in others it doesn't.
 - Focus Area F staff should not be “second class” on communication issues and suggest that there be some F related topics on every NPHIC call.

Response: One survey a few years ago showed that 75% of PHHIC were also Focus Area F staff; however, we are unsure if those statistics are still valid. Note: A poll of roundtable participants showed that less than one-half were also the PIO officer in their state.

New Guidance on Leadership Risk Communication:

- Leadership course is set up to be taught in 4-hour, 6-hour, and 8-hour blocks. Comments revealed that participants would prefer that information be sent “piece meal” as opposed to waiting to complete the entire document.
- A conference for risk communication (Focus Area F) might be a good idea and forum to provide the training.

CDC Issues:

- Next month a media website will go live with materials as supporting every potential public health emergency. The launch will be announced on the NPHIC call. These materials will be included:
 - Fact sheets
 - Information on Shelter in Place
 - Quarantine and Isolation
- The information will be public domain and consistent across federal levels.
- Chad Wood and Carol Simon are CDC contributors to Focus Area F.
- Participants were polled to determine their feelings on having a FA-F person participate on CDC joint site visits. Some of the comments regarding this issue:
 - “Don't want Focus Area F efforts to be discounted.”
 - “Need a PIO Boot camp at CDC to teach risk communication?”
 - “Site visits are just an excuse for CDC folks to go sightseeing and would rather not have to plan for another person”
 - “Get more coming to Atlanta than having CDC come...”

- Some participants agreed that site visits allow them to pull together information and be able to demonstrate some of the things they have been doing. Others agree that it was one method of exchanging information.
- When informed that the new guidance and performance goals would require them to be more outcome oriented, they expressed difficulty in being able to impact this area for several reasons, including:
 - “They are not necessarily perceived to be the lead in that area”
 - “The chief communication officer does not understand what they do”
 - “Not enough staff to staff PODS”
 - “Measurable objectives are not realistic”
 - “Rural states keep losing money and CDC continues to expect more or just as much from them as they do the larger states”
 - “FA-F not perceived to be as important as bio, chem., surveillance, etc”
 - “Too many pet projects not concentrating on core risk communication responsibilities.”
- Risk communication has always had funding challenges. “We now have more money than ever before, so we need to be creative, and have consistency in our jobs”.
- Participants were encouraged to demonstrate “Best Practices” and innovative ways of how to spend money to achieve critical capacities. For example, media marketing firms are not a good use of BTCA funds. We need to build infrastructure and dedicated channels of distribution that prepare us to communicate messages well and consistently to the public. Special population information is also very good. Messages can not be esoteric and theoretical messages if we are to save lives.

Innovative Ideas:

- The National Response Plan is intended to help states communicate in a way to have support on operation plans.
- Public Health needs to get respect from internal and external partners because people are looking to public health for help in emergency response.
- Most states do more than BTCA funds have allowed them to do. Communication is now making in-roads and just recently being called in at the beginning to help out with planning.
- Communication is “not there yet”, but when people call them up they should share and get ideas to gain respect.
- Seek training inside and outside the organization, because people don’t think communication is important until it is needed.
- Participate in exercises. Volunteer to be on planning committees to ensure that communication is a part of the overall planning.
- Only PIOs are usually invited to an exercise. In Alaska, WY, FBI won’t play so they need to ensure forensic epi is provided and this group is invited.
- Barbara Reynolds has been asked by HHS to train all federal agencies including Department of Homeland Security, so maybe there will be more willingness to

participate. States are advised to participate and change what they can and work around the rest.

- For the first time NPHIC is allowing Focus Area F and risk communication to take a lead in conference. One participant has been working with them on this conference and agreed to submit inputs and comments from this group. The conference is scheduled to be held in October in either New Orleans, New York or Orlando. Participants are encouraged to attend.

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EVALUATION AND PERFORMANCE MEASUREMENT

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- Like “Version 1.0” want to tweak it for smaller regions or small Public Health Departments
- States in general want to understand performance indicators and want performance measurement guidance from the CDC
- Discussion on Congressional use of progress reports and the measures they would like to see. Congress likes progress charts and things that show impact, which is difficult to get from narratives.
- Two Big messages:
 - Need compliance/accountability measures that States can use to monitor progress
 - Difficulty complying with spending requirements do to CDC late release of funding
- States want help from CDC measuring their progress in developing their response capabilities.
- Need the establishment/Federal Accreditation of Public Health Response Professionals– Want CDC to measure the ramp-up of this workforce
- States feel they are better prepared, however, they need help measuring real progress.
 - Liked version 1.0
 - “CDC Goals” are not helpful at the state and local level
- Want concrete guidance from CDC
 - States “stress” whenever a progress report is due – Not sure what to report or send
 - Recommend Academia help develop standards or “templates”
 - Current federal measure tool, e.g. FEMA, do not fit the Public Health Model
 - Want CDC to step up to the plate and write standards measures or templates
 - Too many local standards are personality driven – want unbiased ones
 - Want standards “institutionalized”
- Often after action reports or other self assessments are screened by management to take out items that may reflect badly on them or the organization. For example: “take

that out, it makes us look like we do not know what we are doing” or the reports are “political.”

- Want CDC to develop a template assessment tool for States and Counties
- Want outcome based measures
- Like site visits to help with test and evaluation – Problem when it is not standardized across CDC members
- Issues with what the “contractor” reported or how the contractor translated what the States said
 - Do want performance measurement standards, guidelines, templates, etc.
 - Do not want CDC to say this is how they must accomplish any task
 - Want outcome based measures
 - 24/7 is difficult for an across the board measure – not all local levels have the infrastructure to support this (people, equipment, etc)
 - Allow flexibility
 - Contractors sample was too small to get accurate data from the States
- Reporting measures: Add measures and follow-up on MIS, maybe add after action reports/testing

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INFORMATICS

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BOTTOM LINE: “Public health preparedness is at the local level but standards development is national.” (Quote from James Gibson’s comments at the conclusion of the session.)

Program Challenges:

The difficulty in moving toward a universal standards-based reporting and communications system is exacerbated by:

- Significant variability in public health agency and laboratory systems infrastructure and sophistication
- Vendor unwillingness to work with states in creating or modifying products to comply with standards
- Difficulty in getting medical community and clinical labs to adhere to state standards without monetary motivation to do so
- Inter-state data exchange is complicated by the need for a common set of codes; an agreed upon standard vocabulary

- Data quality from disparate systems and entities is a huge issue that is time consuming and costly to address
- Compliance with PHIN standards will be a time and cost intensive activity
- Unclear CDC expectations and timelines
- Lack of a complete definition of PHIN

CDC Issues/Activities:

- Public health standards must fit within the larger framework of other governmental IT standards being developed.
- CDC will soon brief HHS on a process for certification that addresses cross-cutting functionality using an approach that would initially perform baseline assessments for all grantees.
- CDC will also be assessing the magnitude and type of technical assistance needed.
- There are plans to provide grantees with a direct assistance supplemental after the initial award.

Potential Solutions/Innovative Ideas:

- Development of universal national standards:
 - Establish national standards with broad input (from the field, vendors, medical community, etc.)
 - Develop fully defined specifications so that grantees can hand off to vendors for implementation without further definition needed. (Thus avoiding potential for further variability and incompatibility between protocols and systems.)
 - Use a well-managed change control process for the introduction of periodic modifications to standards.
 - Engage and motivate vendors to comply with standards.
 - Develop “translators” for non-compliant private sector systems (clinical labs, hospitals, etc.) and as an interim solution for public health agencies who are operating sophisticated systems that will need time and money to migrate to a new set of standards and architectures.
- PHIN certification:
 - Have grantees develop annual plans that report current functional and technical status as well as specify detailed objectives and activities for advancing the project toward meeting PHIN standards.
 - Use a graded numerical scale (e.g., 1–10 with 10 being fully compliant) to represent a grantee’s maturity level toward full compliance. This would help grantees to more easily communicate their current status and corresponding budgetary needs to local decision-makers and legislature while at the same time facilitate CDC’s ability to categorize and prioritize technical assistance needs of grantees.
- Funding issues:

- Take advantage of economies of scale by CDC purchasing products for national licensing and use.
- Provide contractual vehicles such as those with GSA whereby grantees can rapidly put in place Statements of Work for IT equipment and services through Direct Assistance.
- Work with NACCHO and ASTHO to define broad categories of IT needs that could be addressed with GSA or GSA-like contract mechanisms.
- CDC could significantly assist states by allowing dollars to be carried over into direct assistance. State fiscal year boundaries and procurement regulations are exceptionally rigid and beyond grantee control to change in order to accommodate the BT grant budget period.
- New York tools for standards enforcement (these were noted as tools but not sufficient to overcome monetary barriers):
 - Legislation mandates clinical lab reporting within 24 hours
 - State licensing requires clinical lab reporting to comply with prescribed standards and data formatting

Outstanding Questions:

- When will PHIN be fully defined?
- What is the process that will be used for PHIN certification? (Will it be similar to the processes used for PVS and SARS? These were mentioned as having working well.)
- What is the timeline for PHIN certification and how will states be prioritized for certification?

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PANDEMIC INFLUENZA PLANNING

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Issues Discussed:

- **Quarantine**
 Quarantine will play a different role in an influenza pandemic than SARS, because of the short incubation period and the fact that persons can transmit before even being symptomatic. Quarantine may play an important role early on, but once transmission has reached a certain point it will no longer be feasible. Approaches such as school closures or more wide spread snow days may play a role; the difficult decision will be when to implement them. Must balance the potential benefit against the disruption such measures will cause. CDC is currently developing guidance related to community containment measures.
- **Surge capacity**

Surge capacity is a major issue; health care systems are already taxed as it is. A worst case scenario, such as the 1918 pandemic, will require different approaches than a milder pandemic like the 1968 influenza pandemic.

- **Role of public health**

In spite of the lack of vaccine early on and the limited supply of antiviral medications, public health will play a very central role in coordination and communication, and other specific activities such as conducting surveillance.

- **Antivirals**

Because antivirals currently exist in such limited supply in the stockpile, they will be used preferentially for treatment rather than prophylaxis (prophylaxis is a much less efficient use as people must be prophylaxed for the duration of exposure, and many of those prophylaxed would never have gotten infected anyway). If they are to be used primarily for treatment, then distribution issues are key to ensure early treatment, as these drugs are most effective when treatment is initiated within the first 48 hours of symptom onset. Priority groups have not yet been decided upon; a process that will result in a prioritized list is beginning.

- **Key Planning Activities**

Even in the absence of more specific guidance from CDC, a number of important planning activities need to be taking place at the state and local level. Some of these include identifying all the important partners and engaging them in planning, educating them about the issues, determining who is the lead and who are the others involved for each activity, determining what processes will be used to review information provided by CDC. Exercises teach us over and over again that things fall apart when it isn't clear where responsibilities fall--as much as possible delineating those responsibilities before hand will be useful.

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PARTNERS

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No notes available at this time.

PSYCHOSOCIAL ISSUES

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No notes available at this time.

SMALLPOX VACCINATION

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Revaccination of smallpox responders:

- ACIP discussed the appropriate revaccination intervals two times (October 2003 and February 2004). 3, 5, 10 year, and “Out the Door,” with no recommendation made
- CDC working group is beginning to reconsider issue.
- Roundtable feedback is that states would like to be involved in this process
- Interdisciplinary approach (i.e. Public Health Department/hospital representatives) is needed to develop vaccination recommendations. ACIP should use this approach to not only build trust within communities, but provide ACIP with recommendation on what is really needed.

Has CDC thought of specific areas within cities that would have designated isolation areas?

- Each State is responsible for an internal plan on this and has been asked to designate isolation facilities.
- Some states plan that the first hospital to receive a spox patient would become the isolation facility.
- Connecticut purchased mobile isolation units to deal with smallpox patients which will allow hospitals to continue normal business.
- There should be specific hospital triage protocols in place, as the ER could become overwhelmed during a smallpox incident.
- NJ receives 2–3 calls/year regarding a suspected smallpox case. One of their hospitals was shut down because of such an incident.
- Notification plans are not in place on all levels.
- Some Emergency Departments are not isolating patients with rash and high temperatures.
- Some regional hospitals do not have negative pressure rooms, nor do they have hospital staff vaccinated (questions will then come up as to who will collect the clinical specimen from the patient).
- Infectious control measures can really make a difference in the way hospitals prepare and respond to suspected smallpox cases.

Jurisdictions should maintain the ability to mass vaccinate their entire population.

- States are still developing their large-scale vaccination plans and it is not easy.
- Some states planned to use influenza vaccination as an exercise of their large-scale spox vaccination plans. These exercises had to be cancelled at the last minute due to the influenza vaccine shortage of 2004 and the change in flu vaccination recommendations. Cancellation caused loss of money and community goodwill.

- New Hampshire has over 20 regional sites with vaccination plans. These plans are used to respond to hepatitis A, meningitis, and influenza outbreaks (used as “All-Hazards” plans).

States would like to see more leadership and guidance from CDC on ongoing efforts in Smallpox Preparedness Planning.

- There have been no recent CDC updates to guide smallpox preparedness activities.
- Preparedness is much more than smallpox vaccination.
- Smallpox preparedness and vaccination activities distracted states/locals from other preparedness activities.
- States are interested in forming an emergency response preparedness advisory committee to help inform CDC and states about practical applications and operational activities in emergency preparedness and response planning.
- Connecticut suggested there be state/local based workgroups to provide input around smallpox program activities and planning. These workgroups can provide more of the advising on what direction the smallpox program should be moving in and long term sustainability by not “recreating the wheel.”
- CATO Institute has a lot of information regarding concerns of direction smallpox is moving in. the paper – Smallpox and Bioterrorism, Why the Plan to Protect the Nation is Stalled and What to Do (www.cato.org/pubs/briefs/bp-085es.html) also promotes bringing others to the table (i.e. public health, behavioral science, military, etc).

What is the status of liability and compensation for spox vaccination?

In January 2005, coverage was extended for another 12 months (will now expire January 2006).

Are states having trouble communicating with local military installations?

- The military has not always kept state/local health departments updated on local issues with vaccination and adverse events.
- Kansas has a liaison to the military to keep them abreast of military vaccination activities.

[Select another topic](#)

SPECIAL POPULATIONS – Children and School Health

[Select another topic](#)

Major topics of discussion:

- Much of the discussion involved how do we or should we define “special needs” populations.
- Each grantee is addressing special populations, but there is no or little agreement to what is required.

- Some wanted the CDC Public Health Preparedness cooperative agreement to clearly delineate who fits within “special needs” populations. Perhaps broad categories: Clinical vs. non-clinical
- There needs to be separate classifications for mental health vs. physical impairment (permanent vs. temporary) conditions.
- Needs much broader perspective for disabilities than emergency management context – Be process focused rather than condition focused; depending on the event, various types of individuals could be seen as “special,” so while walking through the process think of the potential barriers that could exist for a variety of individuals.
- Goal: Can anyone move through the system regardless of special needs condition? If not, then identify the gap and address it by planning with persons with expertise.
- CDC should require an appendix to BT plans of how special needs populations are incorporated.
- Clearly needs to have input from the disabilities community. Need to have persons with disabilities be apart of the State/local BT advisory committees, planning, and design and implementation of exercises. (DSLIR cooperative agreement)
- How far do you to go get special populations representatives?
- Most States have a disabilities council, could be some at the local level as well.
- Look at and learn from past experiences—major and smaller events
- No need to reinvent the wheel. There are 16 States that receive CDC funding for disabilities perhaps all grantees can learn from their experiences.
- Need to ensure that State programs talk with one another regarding this issue, especially if funded from CDC. Benefits would include:
 - consistency across communities.
 - If get both sides to talk probably will see themes emerge.
 - use of existing models.
- Persons with disabilities usually do not like the emergency management (first responders) recommendation of using government registries (part of community risk assessment). Too much like Big Brother. Most disability communities are more tolerant of local churches/synagogues, which maintain lists since that is often where assistance is found. Past experiences validate this process. Often government, big registries are lost during event because require electricity and connectivity to share in timely fashion. System does need to reach out, but first responders need training in working with “special needs” persons—cultural competence as well as clinical issues. This is especially true for large cities and counties. Experience shows that smaller communities know who has special needs because everyone knows everyone.
 - Have a tool, “Tips for responders”
 - What about promoting the using vial for life.
 - Lifeline is also a possibility. Many seniors are clients – major database
- Persons with a disability or a special need can take some responsibility for taking additional steps for preparedness if contacted through a credible source that provides the recommendations or outlines the steps.

SPECIAL POPULATIONS–ADULT AND COMMUNITY HEALTH

[Select another topic](#)

Program Challenges:

- How do you address special needs populations?
- How do you conduct training for special populations?
- Do states have plans for each special population and how to address their concerns?
- How do states define special populations?
- How do you accommodate people with disabilities during a disaster?
- Access to medications is an issue, particularly for the elderly.
- Access to electricity is an issue for anyone who needs to refrigerate their medications or is on oxygen.
- How funding should be distributed/allocated to special populations?
- Needs to be more collaboration between states and tribal entities.
- How do we get professional skills set training for staff working with special populations?
- How to serve these populations in a culturally competent manner?
- How do you effectively engage the communities?
- How do we specifically deal with older adults?

CDC Issues:

- How does CDC define special populations?
- How does CDC allocate funding to states and counties to ensure special population's issues are being addressed?
- CDC needs a better plan in addressing this group and should be more specific in the RFP.
- Can CDC provide grants for community facilitation and empowerment, are grants like these available for special populations?
- Can CDC facilitate states using the 211 assistance phone line for emergency purposes?
- Is there flexibility to use CDC dollars to purchase cultural items that may facilitate building trust with special groups?

Innovative Ideas:

- Counties need to develop more special needs shelters.
- Needs to be more partnering with companies that provide home health services and equipment to identify potential special needs individuals.
- Special populations assessments need to be conducted to ensure needs are being met.
- State health departments need to coordinate more with the state units on aging, state disability agencies, and state mental health agencies. These agencies may receive funds for emergency planning and can be a good resource for reaching special populations.
- Need specific tribal needs assessment.
- Use call-in-service program for protocol and syndromic surveillance.
- Work with National Indian Council on the Aging to reach elder tribal populations.

- Use Vials of Life program. Make sure each member of a special population has them in their home.
- Partner with community service providers to ensure stickers are placed on the doors of homes of people with pets to ensure they are taken care of or rescued when there is an emergency.

[Select another topic](#)

STRATEGIC NATIONAL STOCKPILE (SNS)

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Program Challenges:

- There are too many details involved in managing an SNS program.
- Finding an RSS (Receipt, Storage and Staging) site is very challenging.
- Dependency on National Guard is not always practical due to their tiered response during and event. They may become federalized and used in a capacity other than SNS response.
- Political turnover may change priorities and level of support.
- Coordinating with multiple agencies across counties is very difficult. Some administrations want control but do not want to sit at the planning table.
- Legal issues at PODs (Point of Dispensing site) with counties' varying response time.
- Statewide dispensing protocols are needed but local public health authority prohibits this, and some local medical directors will not support this effort. Limited resources make legally binding agreements difficult. The requirements exceed the available funding.
- Volunteer staffing at PODs is extremely challenging. How do you recruit sufficient numbers of volunteers and keep them engaged prior to an event?
- In-state caches of prophylaxis for first responders and their families are very limited or non-existent.
- List of priority populations for administering prophylaxis continues to grow.
- Volunteer medical staff liability issues have not been addressed. Medical volunteers are concerned that they may still be sued individually, even if they are covered by a blanket-immunity policy or Good Samaritan law during an event.
- Worker's Compensation for volunteers and staff is not being addressed.
- Liability coverage should be similar to what was granted during the Smallpox response.
- In areas with military bases, military staff and families may not have access to prophylaxis and need to be included in planning.
- Recruiting pharmacists has been challenging.
- Some states have had large scale events or emergencies (chemical spills, gas leaks, etc.) with a great public health impact, but no governor declaration was granted, which would facilitate the request for the SNS.
- Levels of certification across state or country (Guam) lines may vary significantly.

CDC Issues:

- Funding cannot be spent properly due to its questionable sustained availability, especially CRI funding.
- What is the future status of CRI? Will it continue? Will it expand?
- There is limited accountability at the local/county level.
- Competition among focus areas exists with no guidance from CDC on how to appropriately allocate resources. Project Areas have to rob Peter to pay Paul. Silos are created as funding increases in one, which results in decreases in other areas. CDC does not make allowances for the impact of these changes in technical review recommendations. Recommendations are inconsistent with priority funding changes.
- The color ratings (Red, Amber, and Green) cause problems locally and statewide, especially when decreases occur. Many politicians/leaders do not understand the evaluation of SNS.
- CDC needs to develop standardized Just-In-Time training for volunteers at the state and local level.
- There is limited opportunity for face-to-face interactions between Project Areas (collectively) and SNS to discuss changes and challenges. Participants were encouraged to use the list serves (SNS and CRI) in the interim.

Innovative Ideas:

- In Project Areas with military bases and industries with large populations, caches may need to be stored on military bases and in the industries. These groups should be included in planning.
- During an exercise in one area, graduate students and schools of nursing were used.
- One area reported that it plans to use pharmacy students, who have already been background checked, as volunteers.
- One area reported success in recruiting pharmacists, as a result of having a pharmacist on the state advisory committee, who actively recruit colleagues.
- One area reported having a first-responders waiver to provide prophylaxis in the event of a declaration of an emergency.
- In one areas' SNS plan, request for the SNS is included in the governor's declaration of an emergency.
- One area reported that it is already addressing certification across state lines.
- Educate governors associations about SNS and the importance of their buy-in and support.

[Select another topic](#)

SURGE CAPACITY

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Program Challenges:

- State personnel have multiple duties and responsibilities and will have a difficult time responding to these duties and responsibilities in the case of an event. Cross training of employees and partnerships with local governments and local non-governmental organizations could help reduce this deficiency. Also, the temporary employment of retired health professionals could provide needed resources.
- Trained personnel may not show up for work after an event. The likelihood of an employee reporting to work after an event decreases after each of the following types of events: nuclear, chemical, and biological.
- Triage plan needs to be developed in order to ensure that medical personnel and facilities are used most efficiently. Medical personnel need to be trained for both the physical and emotional severity of an event.
- Public officials need to determine and be able to respond to the impact that an event will have on a community. Officials need an honest and accurate assessment of pre-event vulnerabilities and post event impact trauma in order to be able to return a community back to pre-event status.
- For areas that have a significant level of tourism, plans need be developed and implemented to identify and treat tourists.
- Both medical and non-medical information systems need to be updated and kept current.
- In areas "down stream" from large events requiring mass evacuation coordination with communities in the pathway of these evacuees must also prepare, even if they are far from the event. The impact of an event on the both the highways and public transportation systems needs to be assessed and improved where needed.
- Collaboration between States must be developed, implemented, and constantly evaluated.

CDC Issues:

- CDC must recognize that all disasters are local and that each community will have different requirements for resources, assistance and planning. While general preparedness can be achieved, there is often no one standard solution for the response to an event and CDC must remain flexible to the States' needs.
- Create and fund public service announcements (See Innovative Ideas below).
- Create a surge capacity tool kit for the States.
- Provide security for Stockpile and dispensing locations.

Innovative Ideas:

- Conduct a massive public information campaign. One form could be the use of public service announcements (PSA) that explain how to respond to an event.
- Consider providing (public) transportation to centrally located dispensing sites instead of using the USPS or other similar means to distribute vaccines and/or other medicines.
- Develop and use mobile medical treatment centers (similar to Army MASH units) to treat casualties.

[Select another topic](#)

SYNDROMIC SURVEILLANCE METHODS

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BioSense Overview:

- Henry Rolka and David Walker provided an overview of BioSense. BioSense was developed to support early detection and is designed to connect to information systems that support different public health functions. It is a web-based interface that is accessed through the Secure Data Network. BioSense administrators at the state level approve access for appropriate individuals in their jurisdiction. There are 340+ digital certificates issued for BioSense users in 49 states.
- BioSense utilizes two algorithms. It has the capacity to drill down into the data using zip codes or city. It can send alerts to users to notify them that there is a record with an unusual diagnosis that might require further investigation.
- Julie Rawlings (Texas) indicated that they were notified of a smallpox case recently. Typically, this kind of report is an adverse reaction to vaccination. If the state or local jurisdiction receives records that they have a question about, the BioSense staff can provide assistance – this is a service that CDC provides in support of the application.

BioSense Questions:

- Is it possible to get information on a regional basis? Washington, DC did this during the presidential inauguration. The system has the capability to broaden the jurisdiction to include regional collaborations.
- Delaware attendee inquired about the difference between the data that Delaware receives from LabCorp and what CDC gets from LabCorp. David Walker indicated that it isn't clear what the difference is but that he could work with Delaware to investigate this. Delaware is interested in seeing if the denominators are the same.
- How is the appropriate jurisdiction determined? The jurisdiction for the data that CDC receives is determined by the zip code of the patient. If this is unavailable, the physician's office zip code is used. If that is unavailable, the lab zip code is used.
- What is the cost? There is no cost to states to use BioSense, other than their own costs to provide staff to support BioSense in their jurisdiction. CDC provides user support through email and phone help desk, as well as training.

- How can a state increase the number of users in their jurisdiction? A state can increase the number of BioSense users in their jurisdiction through the following process:
 - State BioSense Administrator submits the names and email addresses to CDC.
 - CDC issues a digital certificate.
 - CDC provides training.
- Who is a state's BioSense Administrator? The state's BioSense Administrator is either the State Health Officer or his/her designee and is often the State Epidemiologist.
- Can you currently get data in a format so that you can use a different analytical model? Not yet but CDC is looking at this. A pilot project may be identified to examine this further.
- Are over the counter medications tracked in BioSense? No. However, a system is still in place to track this. The University of Pittsburgh is doing this. Contact Mike Wagner for more information. There is a cost for this data which could run around \$50,000.

Delaware Overview:

- Dr. Hathcock described the status of Delaware's system, which began 3 years ago. The system uses a logical data model. They contracted with Northrup Grunman. ICPs from the 8 hospitals in Delaware enter cases of reportable diseases on line. This creates public health cases for investigation.
- The syndromic surveillance module has the ED and clinic admissions records from one hospital. Lab data for reportable diseases for inpatient services at this hospital are also included. This information is exchanged a couple of times a day.
- Information Builders is working on web-based reports. This will include the capability to run reports anytime.
- Delaware is looking at CDC OMS and integrating tablet computers and geocoded cases and maps into the system.
- Physicians who are computer literate will be able to enter cases just like a hospital once password and login is provided by the State.
- Everything is restricted based on the user's role. For example, STD staff only receives information on STDs. There are only 4 super users.
- The system cost \$4 million and is statewide. All 8 hospitals and 3 counties are included. Public Health Nurses will be included by May. PHN staff will receive emails about cases that were generated for residents in their county in the last 24 hours. They plan to add CDC supplemental forms. Epidemiologists like the system.

Delaware Questions:

- What were some of the challenges faced? During the design phase, it was a challenge getting people to figure what they needed the system to do up front. It is important that you have a good contractor who can come back with prototypes during the design phase.
 - People are impatient and don't want to wait long for the system to be developed. Most didn't appreciate the complexity of the development process.

- It was necessary to train the contractors as they didn't know anything about syndromic surveillance as well as other terminology.
- HIPAA issues were a concern. The state health officer provided a letter requiring reporting which alleviated these concerns.
- Hospitals are resistant to participating because of money and time. They have to create HL7 messages and trigger the messages to be sent to a certain mailbox. This is not time consuming.
- Did implementation of this system require legislation? Delaware's requirements do not require legislation, but by regulation and public hearing.

Texas Overview:

- Syndromic surveillance is occurring at the local and regional levels only. Locals are given the flexibility to choose from the variety of software that is currently available on the market. There are some home grown systems, like systems for school absenteeism.
- Once the locals start with a system, they want to continue. Technically, the system is supposed to be PHIN compliant but it is difficult to determine if that is always accurate based on the vendor's information. The Texas HAN and NEDSS coordinators have been involved in looking at the systems for PHIN compliance.
- The biggest challenge is getting the data. Systems are available but it becomes more difficult when you look at a system to see if it can do what you really need it to do.

Washington, DC Overview:

- Washington, DC uses Essence. It is embedded in the DC automated disease surveillance system. It is now part of the National Capitol Region system and includes Maryland and Virginia. Even if the system goes down, individual programs can still function.
- Hopkins is conducting research to identify needed updates to the system. DC has found that the system does things they never thought it would be capable of.
- There are signed Memorandums of Understanding with the vendor and the other jurisdictions for data sharing.
- Regarding the regional approach, one of the challenges is to ensure that alerts are managed appropriately so that stakeholders don't notify the media needlessly. Data has to be seen by appropriate staff.
- The system has been internally reviewed for PHIN compliance.

Washington, DC Question:

Delaware is interested in the regional approach. Does DC have any interest in expanding up the Eastern shore to share with Delaware? Yes, DC is interested in expanding to include Delaware and other jurisdictions and plans to explore this.

Utah Overview:

Utah is still using the system that was set up for the 2002 Winter Olympics. They have faced some challenges with their contractors and are interested in contacting other states about their systems.

Recommendation:

Tracee Treadwell stated that at some point, we need to come to agreement on common syndromes. She suggested that States might check the CDC website – <http://www.bt.cdc.gov/surveillance/syndromedef/index.asp> – to see if those listed fit with what you feel is useful. This is a place to start in terms of commonality.

[Select another topic](#)

TRAINING AND EDUCATION

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September Conference:

- CDC may form a “planning committee” that will include one or two representatives for each of the three existing workgroups. It was recommended that local Public Health Officers also be invited to participate in the planning process.
- CDC will initiate regular monthly briefings with state/local Preparedness Education Leads to share progress information and elicit participant feedback.

FY06 Program Announcement:

- A copy of the “draft” guidance was recently shared with select public health partners for review/comment. Roundtable participants requested that the list of partners be provided to all Preparedness Education Leads. It was also recommended that the “draft” guidance be shared with state/local universities for comment.
- Although the need for training and education is discussed in the Cross-Cutting section of the guidance, specific preparedness goals are not included. Participants recommended that education and training be linked with all preparedness goals (e.g., prevent, plan, detect, etc.). Lynn Steele will provide Preparedness Education Leads with clarification on proposed goals, objectives, and activities.
- Given the lack of specificity in the guidance, participants voiced concern that training and education resources may become diluted or eroded in future years. Since training impacts every program component, CDC should reinforce the need to ensure that sufficient funds are available for this purpose.
- The guidance should 1) include specific language regarding the recruitment of qualified professionals to assist with workforce development and 2) require applicants to identify a Preparedness Education Lead in their budget request.

Centers for Public Health Preparedness (CPHP):

- Since approximately \$29 million were allocated to 23 academic institutions in FY05, it has become increasingly important for the CPHP's to demonstrate the impact of advanced trainings on public health preparedness at the state/local levels. CDC should engage its public health partners more on this issue.
- CPHP trainings should be more closely aligned with the "core competencies" (e.g., epidemiology, laboratory, risk communication, etc.) outlined in the FY06 Program Announcement. CDC should collaborate with the Association of Schools of Public Health (ASPH) toward this end. In turn, CPHP's should collaborate with state/city health departments to identify/prioritize need, establish training goals, develop appropriate curricula, etc.
- Currently, CPHP's communicate with CDC indirectly through ASPH. However, there is no mechanism in place for CPHP's to archive information. CDC should develop tools/venues (e.g., distance learning portal, monthly teleconferences, etc.) and/or open forums (e.g., community college "blackboards"), through which curricula and other important information can be shared.
- It was recommended that funding for academic institutions become a separate line item in COTPER's budget and include Congressional "earmarks" for certain CPHP's (e.g., Yale University). In addition, the CPHP initiative should become more closely aligned with Preparedness Goal #10 (after-action evaluation/future action).
- In addition, CDC should improve collaborations with the Department of Homeland Security to share training and education resources, collaborate on joint training ventures, etc.

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